700

Veterans Benefits

Budget function 700 covers programs that offer benefits to military veterans. Those programs, most of which are run by the Department of Veterans Affairs, provide health care, disability compensation, pensions, life insurance, education and training, and guaranteed loans. CBO estimates that outlays for function 700 will total $44.8 billion in 2000, including discretionary outlays of $20.4 billion. Over the past decade, discretionary outlays for veterans' benefits have increased almost every year.

Federal Spending, Fiscal Years 1990-2000 (In billions of dollars)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Estimate 2000
Budget Authority (Discretionary)	13.0	14.1	15.3	16.2	17.2	17.6	17.8	18.9	18.9	19.3	20.9
Outlays											
Discretionary	13.0	13.8	15.1	15.8	16.7	17.4	17.6	18.6	18.5	19.4	20.4
Mandatory	16.1	17.5	19.0	19.8	20.9	20.5	19.4	20.7	23.3	23.8	24.4
Total	29.1	31.3	34.1	35.7	37.6	37.9	37.0	39.3	41.8	43.2	44.8
Memorandum:											
Annual Percentage Change in Discretionary Outlays		5.9	9.8	4.7	5.7	4.3	1.0	5.7	-0.6	4.7	5.1

700-01 Charge Monthly Rather Than Up-Front Fees for VA Mortgage Insurance

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	152	152
2002	137	137
2003	364	364
2004	349	349
2005	327	327
2001-2005	1,329	1,329
2001-2010	2,991	2,991

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

700-04

The Department of Veterans Affairs (VA) operates a home loan guaranty program that insures mortgages for active-duty military personnel and veterans. Borrowers taking advantage of the program pay a one-time, up-front funding fee. In contrast, borrowers using private mortgage insurance generally pay monthly fees.

This option would replace the up-front fee in the VA program with an annual premium, paid monthly, starting in 2001. Budget savings to the VA would total $1.3 billion over five years and $3 billion through 2010. Under current law, the up-front fee will decline in 2003. About half of the saving estimated for this option would come from not reducing that fee in 2003; the other half would come from the additional change to monthly premiums. Actual savings from the option, however, would depend on future economic conditions: savings could be lower if the program experienced high rates of default or high rates of refinancing to conventional loans.

Besides saving money for the VA, changing from an up-front to a monthly fee would have advantages for program participants. First, it would increase fairness among borrowers by charging them for mortgage insurance only for the years that they needed and used it. Active-duty military personnel who regularly change their duty station would pay less than they do under the current fee structure. For example, borrowers who sold their home after five years would save more than $700 (on a present-value basis) with a monthly fee, compared with a 2 percent up-front fee on a loan with no down payment. An additional element of fairness among borrowers would result because the monthly fee would cause borrowers who defaulted on their mortgage to pay significantly more toward their insurance than they do now. When the up-front fee is financed as part of the mortgage—as it typically is today—borrowers who subsequently default pay very little of the fee.

Second, the annual fee assumed in this option (0.35 percent) is significantly lower than premium rates that private mortgage insurers charge for comparable coverage. Thus, the program would continue to provide a significant benefit to military personnel.

Third, because the up-front fee is usually financed as part of the mortgage, adopting a monthly fee would reduce mortgage amounts, making it easier for borrowers to sell their homes, and thus reduce rates of default and foreclosure. Today, since most VA mortgages combine financing of the up-front fee with a zero downpayment, the program creates "upside-down" loans whose balances are greater than the underlying property values. Borrowers in that situation must wait for the price of their home to appreciate significantly before they can afford to sell it and move. If the price does not rise fast enough, default becomes a viable option when the borrower must move to a new location. The January 1999 *Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance* raised concern about upside-down loans and their added risk of default.

Changing the fee structure for VA mortgage insurance could have drawbacks, however. First, the department would need to establish a system to receive monthly premium receipts from lenders, which could necessitate new accounting and computer systems. Second, the change would require borrowers to either make slightly higher monthly mortgage payments (an average of $17 higher during the years in which the premiums were due), purchase homes of lower value (an average of $2,300 lower), or some combination of the two.

700-02 End Future Veterans' Compensation Payments for Certain Veterans with Low-Rated Disabilities

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	22	20
2002	67	64
2003	114	110
2004	163	159
2005	232	229
2001-2005	598	582
2001-2010	2,542	2,503

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

700-03

Approximately 2.3 million veterans who have service-connected disabilities receive veterans' disability compensation benefits. The amount of compensation is based on a rating of the individual's impairment that is intended to reflect an average reduction in the ability to earn wages in civilian occupations. Veterans' disability ratings range from zero to 100 percent (most severe). Veterans who are unable to maintain gainful employment and who have ratings of at least 60 percent are eligible to be paid at the 100 percent disability rate. Additional allowances are paid to veterans who have disabilities rated 30 percent or higher and who have dependent spouses, children, or parents.

About 50,000 veterans with disability ratings below 30 percent are added to the rolls every year, receiving benefits of between $70 and $188 a month. Federal outlays could be reduced by $2.5 billion during the 2001-2010 period by ending benefits for those low-rated disabilities in future cases.

Making veterans with new disability ratings below 30 percent ineligible for compensation would concentrate spending on the most impaired veterans. Performance in civilian jobs depends less now on physical labor than when the disability ratings were originally set, and improved reconstructive and rehabilitative techniques are now available, so physical impairments rated below 30 percent may not reduce veterans' earnings. Those impairments include conditions such as mild arthritis, moderately flat feet, or amputation of part of a finger—conditions that would not affect the ability of veterans to work in many occupations today.

Veterans' compensation could be viewed, however, as career or lifetime indemnity payments owed to veterans disabled to any degree while serving in the armed forces. Moreover, some disabled veterans—especially older ones who have retired—might find it difficult to increase their working hours or otherwise make up the loss in compensation payments.

700-03 End Future Awards of Veterans' Disability or Death Compensation When a Disability Is Unrelated to Military Duties

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	75	69
2002	230	217
2003	393	379
2004	566	552
2005	830	827
2001-2005	2,094	2,044
2001-2010	8,875	8,784

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

700-02 and 700-04

Veterans are eligible for disability compensation if they either receive or aggravate disabilities while on active-duty service. Service-connected disabilities are defined as those resulting from diseases, injuries, or other physical or mental impairments that occurred or were intensified during military service (excluding those resulting from willful misconduct). Disabilities need not be incurred or made worse while performing military duties to be considered service-connected; for example, disabilities incurred while on leave also qualify. The federal government gives death compensation awards to survivors when a service-connected disability is related to the cause of death.

As many as 50 percent of veterans receiving compensation payments may qualify on the basis of injuries or diseases that were neither incurred nor aggravated while performing military duties. Ending disability and death compensation awards in such cases in the future would reduce outlays by almost $8.8 billion over 10 years. Approximately 5 percent of those savings would come from reduced death compensation awards.

This option would make disability compensation of military personnel comparable with that of federal civilian employees under workers' compensation arrangements. However, because military personnel are assigned to places where situations may sometimes be volatile, they have less control than civilians over where they spend their off-duty hours. Therefore, in many cases it might be difficult to determine whether a veteran's disease, injury, or impairment was entirely unrelated to military duties. The formal appeals system of the Department of Veterans Affairs (VA) could be extended to cover rulings specifying that disabling conditions were unrelated to military duties.

Data collected by the VA indicate that more than 200,000 veterans receive a total of $1.3 billion a year in VA compensation payments for diseases that, according to the General Accounting Office (GAO), are generally neither caused nor aggravated by military service. Those diseases include arteriosclerotic heart disease, diabetes mellitus, multiple sclerosis, Hodgkin's disease, chronic obstructive pulmonary disease (including chronic bronchitis and pulmonary emphysema), hemorrhoids, schizophrenia, osteoarthritis, and benign prostatic hypertrophy. Ending new awards only for veterans with those diseases would have a more limited impact than this option because it would not affect all veterans whose compensable disabilities are unrelated to military service. However, it could eliminate compensation for some veterans whose disabilities are not generally service-connected, according to GAO, but whose circumstances constitute an exception to that general conclusion. Such an approach would yield smaller savings than the main option—about $1.4 billion over the 2001-2010 period.

700-04 Eliminate "Sunset" Dates on Certain Provisions for Veterans in the Balanced Budget Act of 1997

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	0	0
2002	0	0
2003	764	764
2004	778	778
2005	825	825
2001-2005	2,367	2,367
2001-2010	6,583	6,581

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

700-03, 700-05, and 700-06

Five provisions in law that affect veterans will cease to apply on September 30, 2002—their "sunset" date. As a result, starting in fiscal year 2003, outlays will be higher than if the provisions remained in effect. Those provisions:

- Protect the monthly benefit for certain pensioners who have no dependents and are eligible for Medicaid coverage for nursing home care, thus lowering pension costs for the Department of Veterans Affairs (VA) but increasing costs for the Medicaid program, which is paid for by the federal and state governments;
- Authorize the Internal Revenue Service to help the VA verify incomes reported by beneficiaries, for the purpose of establishing eligibility for pensions and benefits;
- Increase the fees charged for first-time and repeated use of the veterans' home loan program and make the VA more cost-effective in securitizing loans and acquiring property:
- Authorize the VA to collect from any health insurer that contracts to insure a veteran with service-connected disabilities the reasonable cost of medical care that the VA provides for the treatment of non-service-connected disabilities; and
- Authorize the VA to charge copayments to certain veterans receiving inpatient and outpatient care and outpatient medication from VA facilities.

This option would make the effects of those provisions permanent by eliminating the sunset date in each case. In addition, it would eliminate the VA's current authority to spend the medical care collections. Beginning in 2003, those collections would revert back to the Treasury. If all five provisions were made permanent and medical receipts were deposited in the Treasury, savings during the 2001-2010 period would total almost $6.6 billion compared with the current level of spending.

The main advantage of this option is that it would convert the temporary savings achieved by those provisions into continuing savings. The main disadvantage is that certain veterans or their insurers would be worse off financially. States would also face higher Medicaid costs because of withdrawn federal funds for nursing home care.

700-05 Extend and Increase Copayments for Outpatient Prescriptions Filled at VA Pharmacies

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	0	0
2002	0	0
2003	156	156
2004	211	211
2005	268	268
2001-2005	635	635
2001-2010	2,037	2,037

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

050-21 and 700-04

In 1990, the Congress gave the Department of Veterans Affairs (VA) temporary authority to charge copayments for care and services at VA facilities to certain veterans—namely, those with relatively high income and no service-connected disabilities. Copayments for outpatient prescriptions filled at VA pharmacies were set at $2 for a 30-day supply of drugs. The Congress later extended the authority to collect that copayment through 2002 but did not increase the copayment amount, even though the VA's prescription drug expenditures rose by an average of 11 percent per year between 1991 and 1999. The Millennium Health Care and Benefits Act of 1999 has given the VA authority to charge more than $2 for a 30-day supply of drugs, but the department does not yet know how it will implement that authority or what the final copayment will be. (Any increase in revenues would not count as savings since the VA also has authority to spend the money.)

This option would make three sets of changes. First, it would eliminate the provision under which the copayment will expire in 2002 and would extend that payment indefinitely. It would also require the VA to collect copayments in all applicable cases and would remove the department's discretion to waive the copayment. Currently, the VA bills veterans from a central office on the basis of information forwarded by VA pharmacies. Under this option, copayments would be collected by those pharmacies as they dispensed prescriptions. Second, this option would increase the copayment amount by $1 each year until it reached $5 for a 30-day supply. Third, the option would send those collections to the Treasury rather than allowing the VA to spend them, as under current law. Those three actions would take effect in 2003 and would save more than $2 billion through 2010.

Proponents would argue that eventually requiring a $5 copayment for prescription drugs would encourage more prudent consumption and make the VA drug benefit consistent with that of other health care delivery systems, including managed care plans in the private sector.

Opponents, by contrast, would charge that some veterans with multiple chronic illnesses could be overburdened by the higher cost sharing. Even limiting the number of prescriptions subject to copayments in one month could place an undue financial burden on chronically ill veterans and their families, according to critics.

700-06 Increase Beneficiaries' Cost Sharing for Care at VA-Operated Nursing Facilities

	Savings (Millions of dollars)	
	Budget Authority	Outlays
2001	182	182
2002	188	188
2003	194	194
2004	200	200
2005	206	206
2001-2005	970	970
2001-2010	2,097	2,097

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

700-04

Veterans may receive long-term care in nursing homes operated by the Department of Veterans Affairs (VA) depending on the availability of resources. That care is rationed primarily on the basis of service-connected disabilities and income. Under certain conditions, a veteran may receive care at the VA's expense in state-operated or privately run nursing facilities.

The VA may charge copayments to veterans with no service-connected disabilities and high enough income when they receive more than 90 days of care in VA-run nursing homes. In 1998, the copayment rate was equivalent to about $13 a day. A study by the General Accounting Office found that the copayment recovers just 0.1 percent of the costs of providing nursing home care. In contrast, state-operated nursing facilities for veterans and community long-term care facilities that treat veterans have their own copayment policies. As a result, those facilities offset a larger share of their operating expenses than the VA, recovering as much as 43 percent through copayments. (Estate-recovery programs are another way they offset costs.)

This option would authorize the VA to revise its cost-sharing policies to recover more of the cost of providing care in VA nursing facilities. The department would be required to collect a minimum of 10 percent of its operating costs, but it could determine the type of copayments charged and who would be eligible to pay them. For example, it could apply the current copayment to a broader category of veterans or require the veterans who now make copayments to pay more. Recovering 10 percent of the VA's operating costs would save $182 million in 2001 and $2 billion over 10 years. Achieving those savings would require depositing the receipts in the Treasury rather than allowing the VA to retain and spend them. (The Millennium Health Care and Benefits Act of 1999 gave the VA authority to increase copayments charged to the above-mentioned veterans, but the department does not yet know how it will implement that authority or what the structure of copayments will be. Furthermore, any increase in revenues would not count as savings since the VA has authority to spend the money.)

Proponents of this option would argue that veterans in VA nursing facilities are getting a far more generous benefit than similar veterans in non-VA facilities. Because VA-run nursing homes are relatively scarce, veterans lucky enough to be admitted to one receive an unfair advantage over similarly situated veterans. Recovering more of the expense at VA facilities would make that benefit more equitable among veterans and different sites of care.

Opponents of this option would argue that beneficiaries in nursing facilities may be less able to make copayments than beneficiaries receiving other types of care. They would also argue that allowing the VA to charge veterans with service-connected disabilities would be inconsistent with other medical benefits that those veterans receive. The VA could continue to exempt those veterans, but it would have to charge high-income veterans without service-connected disabilities even more to achieve the 10 percent recovery level.